Medical Skin Therapeutics

**Paulina Collins, R.N., L.E.**
**Emily Meyers, R.N., L.E.**
**Yvette Drapeaux, L.E.**

Date: _____

## CLIENT INFORMATION

**Name**_____

**Address**_____

**City**_____**State**_____**Zip**_____

**E-Mail Address**_____

**Home Phone**_____ **Work Phone**_____ **Cell**_____

**Occupation** _____ **How did you hear about us?** _____

## MEDICAL INFORMATION

**Date of Birth**_____ **Age**_____ **Height**_____ **Weight**_____

**Sex: F M**

**Do You Smoke? ____ How Often? _____ Live w/smoker? ____**

**Do you drink Alcohol? ____ How Often? _____**

**Have you ever been treated for:** ***(please circle)***

**Acne Skin Disease High Blood Pressure Cold Sores Diabetes Cancer Sinus**

**Medications Currently Taking:**

_____
_____
_____

**Are you Pregnant? _____ Trying to get Pregnant? _____ Breast Feeding? _____**

**Are you on Hormone Therapy/Birth Control? _____**

**Do you have any allergies? ( Y ) or ( N ) Please List:**

_____
_____
_____

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## PERSONAL INFORMATION

**Have you had cosmetic surgery? _____**

**Have you ever been under the treatment plan of a:**

**Dermatologist_____ Plastic Surgeon _____** Nurse **Aesthetician _____ Over the counter help_____**

**If so, were you satisfied with the results?**

_____

**What skin care line(s) (including make-up) are you currently using?**

_____

_____

**Are you using or have you used (when)?**

**____Glycolic/Salicylic Acid ____Retin-A ____Renova ____Accutane**

**Circle how you feel about the overall quality of your skin: 1(bad) 2 3 4 5 6 7 8 9 10 (fantastic)**

**Would you describe your skin as? (Please circle ONLY one)**
**Normal Dry/Dehydrated Oily Acne/Acne Prone Red/Brown Spots**

**What would you like to see improved in your skin? _____**

_____

**Please check all treatments/services that interest you:**

| | | |
|---|---|---|
| **____Professional Skin Care Program** | **_____Peel Treatments** | **_____Femilift** |
| **____ IPL Laser Treatments** | **_____Laser Resurfacing** | **_____Botox/Fillers** |
| **_____Spray Tanning** | **_____ Hair Removal** | **_____Make Up** |
| **_____Medical Facials** | **_____ Fat Reduction** | **_____Sun Damage** |
| | | **_____Waxing** |

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**I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.**

**Patient Signature: _____**

**Print Patient Name: _____**

**Date: _____**

***We expect payment at the time services are rendered. We do not accept insurance and are strictly billed as a cosmetic procedure. Payment is accepted in the following forms: VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, PERSONAL CHECK OR CASH. We thank you for choosing Medical Skin Therapeutics and hope you enjoy our warm, nurturing atmosphere.***